Uniform Benefits

The Group Insurance Board adopted a uniform medical insurance benefits package for alternate health plans. This affects State of Wisconsin employees and annuitants, and local government employees whose employers participate in the Department of Employee Trust Funds (ETF) health insurance programs.

The purpose of Uniform Benefits is to help contain the rising cost of health insurance and simplify the selection of a health plan for employees. Employees are able to decide on which plan to select on the basis of:

1. Cost of the plan to them
2. Qualify of services provided
3. Access to specific physicians or other health care providers
4. Drug prior authorization requirements
5. Plan referral policies

Uniform Benefits does not mean that all plans will treat all illnesses in an identical manner. Treatment will vary depending on the needs of the patient, the physicians involved and the managed care policies and procedures of each insurance plan.

The following pages describe the benefits which will be offered by all HMOs in 2003. Your plan is not required to provide a separate description of benefits. **It is very important that you keep this brochure for your reference throughout 2003.** If you have questions, please contact the plans directly.

The Uniform Benefits will cover some oral surgery, but alternate plans also have the option of offering other dental benefits. **Plans offering dental benefits are listed on page G-3.**

Uniform Benefits do not apply to the Standard Plan, Standard Plan II, the State Maintenance Plan (SMP), or Medicare Plus $100,000.

NOTABLE CHANGES TO UNIFORM BENEFITS

EFFECTIVE JANUARY 1, 2003

Topic	*Page*	*Section*	*Year 2003 Benefit*	*Year 2002 Benefit*
Lifetime Maximum	D-5	Schedule of Benefits	$2,000,000	$1,000,000
Prescription Drug Copay	D-5	Schedule of Benefits	$5 Generic drug, $17.25 Brand name drug copay	$5 Generic drug, $10 Brand name drug copay
Annual Prescription Drug Out-of-Pocket Maximum	D-5, D-23	Schedule of Benefits and Section III., C., 2.	$300 per person $600 per family	$270 per person $540 per family
Cochlear Implants	D-6	Schedule of Benefits	80% Coverage as Medically Necessary	Excluded
Ambulance	D-5, D-16	Schedule of Benefits and Section III., A., 9.	100% as Medically Necessary	Up to $300 ground, $1,000 air, per occurrence, then 20% Coinsurance
Prescription Drug day supply	D-23	III., C., 2.	30 day supply non-oral contraceptives. One copay per package for oral contraceptives	34 day supply
Orthoptics	D-31	IV., A., 12., w.	Two sessions as Medically Necessary	Excluded

The benefit changes described above are the notable revisions to Uniform Benefits for 2003. Other minor modifications have been made to clarify the intent of specific contract language, however, these clarifications do not change your level of coverage.

If you wish to view the Uniform Benefits section of the “It’s Your Choice” booklet in a format that shows all deleted and added language for 2003, you may access that document through the Department of Employee Trust Funds’ web site at etf.wi.gov.

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I. SCHEDULE OF BENEFITS

All benefits are paid according to the terms of the Master Contract between the Plan and the Department of Employee Trust Funds. Uniform Benefits and this Schedule of Benefits are wholly incorporated in the Master Contract. The Schedule of Benefits describes certain essential dollar or visit limits of your coverage and certain rules, if any, you must follow to obtain covered services. In some situations (e.g., Emergency services received from a Non- Plan Provider), benefits will be determined according to the Usual and Customary Charge. A change to another Plan will result in all benefit maximums restarting at $0.

The benefits of this State Plan are subject to the following:

- Policy Deductible: **NONE**

  Policy Coinsurance: As described below

  Lifetime Maximum Benefit: **$2,000,000 per Participant**

- Ambulance: Paid in full as medically necessary

- Diagnostic Services Limitations: **NONE**

- Outpatient Physical, Speech and Occupational Therapy Maximum: Paid in full up to 50 visits for all therapies combined per contract year. Additional Medically Necessary visits may be authorized by the Plan, up to a maximum of 50 visits per therapy per contract year.

- Prescription Drugs/Brand Insulin Brand Copayment: $17.25
  Generic Copayment: $5.00

  Annual Out-of-Pocket Maximum: $300 per Participant or $600 per family. (Applies to Prescription Drugs/Brand Insulin/Disposable Diabetic Supplies)

- Medical Supplies, Durable Medical Equipment and Durable and Disposable Diabetic Supplies Coinsurance: 20% per purchase or rental. Out-of-pocket expense will not exceed $500.00 annually per Participant. (Out-of-pocket expense for Disposable Diabetic Supplies will be applied to the Prescription Drug Annual Out-of-Pocket Maximum.)

  One hearing aid per ear every three years payable at 80%, up to a maximum of $1000 per hearing aid. The Participant's out-of-pocket costs are not applied to the annual out-of-pocket maximum for durable medical equipment.

- Home Care Benefits Maximum: 50 visits per Participant per contract year. Fifty additional Medically Necessary visits per contract year may be authorized by the Plan.

- Hospice Care Benefits: Paid in full when the Participant's life expectancy is 6 months, as authorized by the Plan.

- Transplants: Limited to transplants listed in Benefits and Services Section, subject to a lifetime benefit of $500,000 for transplants, including Preoperative and Postoperative care.

- Cochlear Implants when medically necessary and prior authorized by the Plan, payable at 80%.

- Smoking Cessation: Covered under the Prescription Drug benefit for a maximum of one three-month course of pharmacotherapy per year.

- Licensed Skilled Nursing Home Maximum: 120 days per Benefit Period payable for Skilled Care.

- Mental Health/Alcohol/Drug Abuse Services:

  Outpatient Services: $1800 maximum per Participant per contract year
  Transitional Services: $2700 maximum per Participant per contract year
  Inpatient Services: 30 days or $6300, whichever is less, per Participant per contract year

  Maximum Benefit: The maximum benefit for inpatient, outpatient and transitional services is $7000 per Participant per contract year.

  The maximum is determined using the average amount paid to the providers by the Plan. The benefit is not subject to copayment.

  Note: Annual dollar maximums for mental health only services are suspended.

  Annual dollar maximums remain in force for treatment of alcohol and drug abuse. Any benefits paid during the year for mental health services will be applied toward the annual benefit maximum for alcohol and drug abuse treatment when determining whether benefits for alcohol and drug abuse treatment remain available.

- Vision Services: One routine exam per contract year.

- Oral Surgery: Limited to procedures listed in Benefits and Services Section.

- Temporomandibular Disorders: The maximum benefit for diagnostic procedures and non- surgical treatment is $1250 per Participant per contract year.

- Dental Services: No Coverage provided under Uniform Benefits. However, each Plan may choose to provide a dental plan to all of its members.

- Hospital Emergency Room Copayment: $40 per visit; waived if admitted as an inpatient directly from the emergency room.

II. DEFINITIONS

The terms below have special meanings in this Plan. Defined terms are capitalized when used in the text of this Plan.

- **BED AND BOARD**: Means all Usual and Customary Hospital charges for: Room and meals; and (b) all general care needed by registered bed patients.

- **BENEFIT PERIOD**: Means the total duration of Confinements that are separated from each other by less than 60 days.

- **CONFINEMENT/CONFINED**: Means (a) the period of time between admission as an inpatient or outpatient to a Hospital, AODA residential center, Skilled Nursing Facility or licensed ambulatory surgical center on the advice of your physician; and discharge therefrom, or (b) the time spent receiving Emergency Care for illness or injury in a Hospital. Hospital swing bed Confinement is considered the same as Confinement in a Skilled Nursing Facility. If the Participant is transferred to another facility for continued treatment of the same or related condition, it is one Confinement.

- **CONGENITAL**: Means a condition which exists at birth but is not hereditary.

- **COINSURANCE**: A specified percentage of the charges that the Participant or family must pay each time those covered services are provided, subject to any maximums specified in the Schedule of Benefits.

- **COPAYMENT**: A specified dollar amount that the Participant or family must pay each time those covered services are provided, subject to any maximums specified in the Schedule of Benefits.

- **CUSTODIAL CARE**: Provision of room and board, nursing care, personal care or other care designed to assist an individual who, in the opinion of a plan physician, has reached the maximum level of recovery. Custodial care is provided to Participants who need a protected, monitored and/or controlled environment or who need help to support the essentials of daily living. The Participant shall not be under active medical, surgical or psychiatric treatment to reduce the disability to the extent necessary for the Participant to function outside of a protected, monitored and/or controlled environment or it cannot reasonably be expected, in the opinion of the plan physician, that the medical or surgical treatment will enable that person to live outside an institution.

  Custodial Care also includes rest cures, respite care, and home care provided by family members.

- **DEPENDENT**: Means the Subscriber's:
  - spouse
  - unmarried children
  - legal wards who become legal wards of the Subscriber prior to age 19, but not temporary wards
  - adopted children and children placed for adoption as provided for in Wis. Stat. § 632.896. Adoptive children become Dependents when placed in the custody of the parent
  - stepchildren
  - grandchildren if the parent is a Dependent child. The Dependent grandchild will be covered until the end of the month in which the Dependent child turns age 18.

  Dependent children must be dependent on the Subscriber (or the other parent) for at least 50% of their support and maintenance and meet the support tests as a Dependent for federal income tax purposes, whether or not the child is claimed.

  Children born outside of marriage become Dependents of the father on the date of the court order declaring paternity or on the date the acknowledgment of paternity is filed with the Department of Health and Family

Services or the equivalent if the birth was outside of the state of Wisconsin. The effective date of coverage will be the date of birth if a statement of paternity is filed within 60 days of the birth.

A spouse and stepchildren cease to be Dependents at the end of the month in which a divorce decree is entered. Other children cease to be Dependents at the end of the calendar year in which they turn 19 years of age or cease to be Dependent for support and maintenance, or at the end of the month in which they marry, whichever occurs first, except that:

1. Children age 19 or over who are full-time students, if otherwise eligible, cease to be DEPENDENTS at the end of the calendar year in which they cease to be full-time students or in which they turn age 25, whichever occurs first.

   Student status includes any intervening vacation period if the child continues to be a full- time student. Student means a person who is enrolled in an institution, which provides a schedule of courses or classes and whose principal activity is the procurement of an education. Full-time status is defined by the institution in which the student is enrolled. Per the Internal Revenue Service, this includes elementary schools, junior and senior high schools, colleges, universities, and technical, trade and mechanical schools. It does not include on-the-job training courses, correspondence schools and night schools.

2. If otherwise eligible, children who are, or become, incapable of self-support because of a physical or mental disability which can be expected to be of long-continued or indefinite duration, continue to be, or resume their status of, Dependents regardless of age or student status, so long as they remain so disabled. The child must have been previously covered as an eligible Dependent under this program in order to continue or resume coverage.

3. A child who is considered a Dependent ceases to be a Dependent on the date the child becomes insured as an Eligible Employee.

4. Legal Wards cease to be Dependents at the end of the month in which they cease to be wards.

Any Dependent eligible for benefits will be provided benefits based on the date of eligibility, not on the date of notification to the Plan.

- **EFFECTIVE DATE**: The date, as certified by the Department of Employee Trust Funds and shown on the records of the plan, on which the Participant becomes enrolled and entitled to the benefits specified in the contract.

- **ELIGIBLE EMPLOYEE**: As defined under Wis. Stats. §§ 40.02 (25) or 40.02 (46) or Wis. Stats. § 40.19 (4) (a), of an employer as defined under Wis. Stats. § 40.02 (28), Employers, other than the state, must also have acted under Wis. Stats. § 40.51 (7), to make health care coverage available to its employees.

- **EMERGENCY**: Means a medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, to lead a reasonably prudent layperson to reasonably conclude that a lack of medical attention will likely result in any of the following:

  1. Serious jeopardy to the Participant's health. With respect to a pregnant woman, it includes serious jeopardy to the unborn child.

  2. Serious impairment to the Participant's bodily functions.

  3. Serious dysfunction of one or more of the Participant's body organs or parts.

     Examples of Emergencies are listed in Section II., A., 1., e.

- **EXPENSE INCURRED**: Means an expense at or after the time the service or supply is actually provided - not before.

- **EXPERIMENTAL**: The use of any service, treatment, procedure, facility, equipment, drug, device or supply for a Participant's illness or injury that, as determined by the Plan: (a) requires the approval by the appropriate federal or other governmental agency that has not been granted at the time it is used; or (b) isn't yet recognized as acceptable medical practice to treat that illness or injury for a Participant's illness or injury. The criteria that the Plan uses for determining whether or not a service, treatment, procedure, facility, equipment, drug, device or supply is considered to be experimental or investigative include, but are not limited to: (a) whether the service, treatment, procedure, facility, equipment, drug, device or supply is commonly performed or used on a widespread geographic basis; (b) whether the service, treatment, procedure, facility, equipment, drug, device or supply is generally accepted to treat that illness or injury by the medical profession in the United States; (c) the failure rate and side effects of the service, treatment, procedure, facility, equipment, drug, device or supply; (d) whether other, more conventional methods of treating the illness or injury have been exhausted by the Participant; (e) whether the service, treatment, procedure, facility, equipment, drug, device or supply is medically indicated; (f) whether the service, treatment, procedure, facility, equipment, drug, device or supply is recognized for reimbursement by Medicare, Medicaid and other insurers and self-funded plans.

- **FORMULARY**: A list of prescription drugs, established by a committee of Plan physicians and pharmacists, which are determined to be medically- and cost-effective. If a Participant or provider requests a non-formulary drug, the Plan may require that it be prior-authorized before it will be covered under the prescription drug benefit. The Formulary may be revised as deemed necessary by the Plan.

- **GRIEVANCE**: Means a written complaint filed with the Plan concerning some aspect of the Plan. Some examples would be a rejection of a claim, denial of a formal referral, etc.

- **HOSPICE CARE**: Means services provided to a Participant whose life expectancy is six months or less. The care is available on an intermittent basis with on-call services available on a 24-hour basis. It includes services provided in order to ease pain and make the Participant as comfortable as possible. Hospice Care must be provided through a licensed Hospice Care provider approved by the Plan.

- **HOSPITAL**: Means an institution that:

  1. (a) Is licensed and run according to Wisconsin laws, or other applicable jurisdictions, that apply to Hospitals; (b) maintains at its location all the facilities needed to provide diagnosis of, and medical and surgical care for, injury and illness; (c) provides this care for fees; (d) provides such care on an inpatient basis; (e) provides continuous 24-hour nursing services by registered graduate nurses; or

  2. (a) Qualifies as a psychiatric or tuberculosis Hospital; (b) is a Medicare provider; and (c) is accredited as a Hospital by the Joint Commission of Accreditation of Hospitals.

  The term Hospital does not mean an institution that is chiefly: (a) a place for treatment of chemical dependency; (b) a nursing home; or (c) a federal hospital.

- **HOSPITAL CONFINEMENT** or **CONFINED IN A HOSPITAL**: Means (a) being registered as a bed patient in a Hospital on the advice of a Plan Provider; or (b) receiving Emergency care for illness or injury in a Hospital. Hospital swing bed Confinement is considered the same as confinement in a Skilled Nursing Facility.

- **IMMEDIATE FAMILY**: Means the Dependents, parents, brothers and sisters of the Participant and their spouses.

- **MAINTENANCE THERAPY**: Means ongoing therapy delivered after an acute episode of an illness or injury has passed. It begins when a patient's recovery has reached a plateau or improvement in his/her condition has slowed or ceased entirely and only minimal rehabilitative gains can be demonstrated. The determination of what constitutes "Maintenance Therapy" is made by the Plan after reviewing an individual's case history or treatment plan submitted by a therapist.

- **MEDICALLY NECESSARY**: A service, treatment, procedure, equipment, drug, device or supply provided by a Hospital, physician or other health care provider that is required to identify or treat a Participant's illness or injury and which is, as determined by the Plan: (1) consistent with the symptom(s) or diagnosis and treatment of the Participant's illness or injury; (2) appropriate under the standards of acceptable medical practice to treat that illness or injury; (3) not solely for the convenience of the Participant, physician, Hospital or other health care provider; (4) the most appropriate service, treatment, procedure, equipment, drug, device or supply which can be safely provided to the Participant and accomplishes the desired end result in the most economical manner.

- **MEDICARE**: Title XVIII (Health Insurance Act for the Aged) of the United States Social Security Act, as added by the Social Security Amendments of 1965 as now or hereafter amended.

- **MEDICAID**: Means a program instituted pursuant to Title XIX (Grants to States for Medical Assistance Program) of the United States Social Security Act, as added by the Social Security Amendments of 1965 as now or hereafter amended.

- **MISCELLANEOUS HOSPITAL EXPENSE**: Means Usual and Customary Hospital ancillary charges, other than bed and board, made on account of the care necessary for an illness or other condition requiring inpatient or outpatient hospitalization for which Plan Benefits are available under this Plan.

- **NON-EXPERIMENTAL**: Means: (a) any discrete and identifiable technology, regimen or modality regularly and customarily used to diagnose or treat illness; and (b) for which there is conclusive, generally accepted evidence that such technology, regimen or modality is safe, efficient and effective.

- **NON-PLAN PROVIDER**: Means a provider who does not have a signed Participating Provider agreement and is not listed on the most current edition of the Plan's professional directory of plan providers.

- **OUT-OF-AREA SERVICE**: Means any services provided to Participants outside the Plan Service Area.

- **PARTICIPANT**: The Subscriber or any of his/her Dependents who have been specified for enrollment and are entitled to benefits.

- **PLAN**: The HMO or PPP providing health insurance services under the Group Insurance Board's program and which is selected by the Subscriber to provide the uniform benefits during this contract year.

- **PLAN BENEFITS**: Comprehensive prepaid health care services and benefits provided by the Plan to Participants in accordance with its contract with the Group Insurance Board.

- **PLAN DEPENDENT**: Means a Dependent who becomes a Participant of the Plan.

- **PLAN PROVIDER**: A provider who has agreed in writing by executing a participation agreement to provide, prescribe or direct health care services, supplies or other items covered under the policy to Participants. The provider's written participation agreement must be in force at the time such services, supplies or other items covered under the policy are provided to a Participant. The Plan agrees to give you lists of affiliated providers. Some providers require prior authorization by the Plan in advance of the services being provided.

- **PLAN SERVICE AREA**: Specific zip codes in those counties in which the affiliated physicians are approved by the Plan to provide professional services to Participants covered by the Plan.

- **POSTOPERATIVE CARE: Means** the medical observation and care of a Participant necessary for recovery from a covered surgical procedure.

- **PREOPERATIVE CARE: Means** the medical evaluation of a Participant prior to a covered surgical procedure. It is the immediate preoperative visit in the Hospital or elsewhere necessary for the physical

examination of the Participant, the review of the Participant's medical history and assessment of the laboratory, x-ray and other diagnostic studies. It does not include other procedures done prior to the covered surgical procedure.

- **PRIMARY CARE PROVIDER**: Means a Plan Provider who is a physician named as a Participant's primary health care contact. He/She provides entry into the Plan's health care system. He/She also (a) evaluates the Participant's total health needs; and (b) provides personal medical care in one or more medical fields. When medically needed, he/she then preserves continuity of care. He/She is also in charge of coordinating other provider health services and refers the Participant to other Providers of Health Care.

  You must name your Primary Care Provider on your enrollment application or in a later written notice of change. Each family member may have a different primary physician.

- **PROVIDERS OF HEALTH CARE**: Means (a) doctors, Hospitals, and clinics; and (b) any other person or entity licensed by the State of Wisconsin, or other applicable jurisdiction, to provide one or more Plan Benefits.

- **REFERRAL**: When a Participant's Primary Care Provider sends him/her to another provider for covered services. In many cases, the referral must be in writing and on the Plan prior authorization form and approved by the Plan in advance of a Participant's treatment or service. Referral requirements are determined by each Plan. The authorization will state: a) the type or extent of treatment authorized; and b) the number of prior authorized visits and the period of time during which the authorization is valid.

- **SCHEDULE OF BENEFITS**: The document that is issued to accompany this document which details specific benefits for covered services provided to Participants by the plan you elected.

- **SKILLED CARE**: Means medical services rendered by registered or licensed practical nurses; physical, occupational, and speech therapists. Patients receiving Skilled Care are usually quite ill and often have been recently hospitalized. Examples are patients with complicated diabetes, recent stroke resulting in speech or ambulatory difficulties, fractures of the hip and patients requiring complicated wound care. In the majority of cases, "Skilled Care" is necessary for only a limited period of time. After that, most patients have recuperated enough to be cared for by "nonskilled" persons such as spouses, children or other family or relatives. Examples of care provided by "nonskilled" persons include: range of motion exercises; strengthening exercises; wound care; ostomy care; tube and gastrostomy feedings; administration of medications; and maintenance of urinary catheters. Daily care such as assistance with getting out of bed, bathing, dressing, eating, maintenance of bowel and bladder function, preparing special diets or assisting patients with taking their medicines; or 24-hour supervision for potentially unsafe behavior, do not require "Skilled Care" and are considered Custodial.

- **SKILLED NURSING FACILITY**: Means an institution which is licensed by the State of Wisconsin, or other applicable jurisdiction, as a skilled nursing facility.

- **STATE**: Means the State of Wisconsin as the policyholder.

- **SUBSCRIBER**: An Eligible Employee who is enrolled for (a) single coverage; or (b) family coverage and whose Dependents are thus eligible for benefits.

- **URGENT CARE**: Means care for an accident or illness which is needed sooner than a routine doctor's visit. If the accident or injury occurs during the Participant's temporary absence from the Plan Service Area, this does not include follow-up care unless such care is necessary to prevent his/her health from getting seriously worse before he/she can reach his/her Primary Care Provider. It also does not include care that can be safely postponed until the Participant returns to the Plan Service Area to receive such care from a Plan Provider.

- **USUAL AND CUSTOMARY CHARGE**: An amount for a treatment, service or supply provided by a non-plan health care provider that is reasonable, as determined by the Plan, when taking into consideration, among

other factors determined by the Plan, amounts charged by health care providers for similar treatment, services and supplies when provided in the same general area under similar or comparable circumstances and amounts accepted by the health care provider as full payment for similar treatment, services and supplies. In some cases the amount the Plan determines as reasonable may be less than the amount billed. In these situations the Participant is held harmless for the difference between the billed and paid charge(s), other than the Copayments or Coinsurance specified on the Schedule of Benefits, unless he/she accepted financial responsibility, in writing, for specific treatment or services prior to receiving services. Charges for Hospital or other institutional Confinements are incurred on the date of admission. All others are incurred on the date a Participant receives the service or item. The benefit levels that apply on the Hospital admission date apply to the charges for the covered expenses incurred for the entire Confinement regardless of changes in benefit levels during the Confinement.

- **YOU/YOUR**: The Subscriber.

III. BENEFITS AND SERVICES

The benefits and services which the Plan agrees to provide to Participants, or make arrangements for, are those set forth below. These services and benefits are available only if, and to the extent that, they are provided, prescribed or directed by the Participant's Primary Care Provider (except in the case of plan chiropractic services, Emergency or Urgent Care), and are received after the Participant's Effective Date.

Hospital services must be provided by a Plan Hospital. In the case of non-emergency care, the Plan reserves the right to determine in a reasonable manner the provider to be used. In cases of Emergency or Urgent Care services, Plan Providers and Hospitals must be used whenever possible and reasonable (see items A. 1. and 2. below).

The Plan reserves the right to modify the list of Plan Providers at any time, but will honor the selection of any provider listed in the current provider directory for the duration of that contract year unless that provider left the plan due to normal attrition (i.e., retirement, death or a move from the Plan Service Area or as a result of a formal disciplinary action).

Except as specifically stated for Emergency and Urgent Care, you must receive the Plan's written prior authorization for covered services from a Non-Plan Provider. The plan may also require prior authorization for other services.

Subject to the terms and conditions outlined in this Plan and the attached Schedule of Benefits, a Participant, in consideration of the Employer's payment of the applicable Plan premium, shall be entitled to the benefits and services described below.

Benefits are subject to: (a) Any Copayment, Coinsurance and other limitations shown in the Schedule of Benefits; and (b) all other terms and conditions outlined in this Plan. All services must be Medically Necessary, as determined by the Plan.

A. Medical/Surgical Services

1. Emergency Care

a. Medical care for an Emergency, as defined in Section I. Refer to the Schedule of Benefits for information on the Emergency Room Copayment.

b. Plan Hospital Emergency rooms should be used whenever possible. Should you be unable to reach your Plan Provider, go to the nearest appropriate medical facility. If you must go to a Non-Plan Provider for care, call the Plan by the next business day or as soon as possible and tell the Plan where you are receiving Emergency care. Follow-up care must be received from a Plan Provider unless it is prior authorized by the Plan. Emergency care received from a non-plan provider will be covered at the same level of benefits as services provided by a Plan Provider. This out-of-plan emergency care may be subject to Usual and Customary Charges.

c. It is the Member's (or another individual on behalf of the member) responsibility to notify the Plan of Emergency or Urgent Out-of-Area Hospital admissions or facility Confinements by the next business day after admission or as soon as reasonably possible. Out-of-Area Service means medical care received outside the defined Plan Service Area.

d. Emergency services include reasonable accommodations for repair of durable medical equipment as Medically Necessary.

e. Some examples of Emergencies are:
   - Acute allergic reactions
   - Acute asthmatic attacks

- Convulsions
- Epileptic seizures
- Acute hemorrhage
- Acute appendicitis
- Coma
- Heart attack
- Attempted suicide
- Suffocation
- Stroke
- Drug overdoses
- Loss of consciousness
- Any condition for which you are admitted to the Hospital as an inpatient from the emergency room

2. Urgent Care

a. Medical care received in an urgent care situation as defined in Section I. URGENT CARE IS NOT EMERGENCY CARE. It does not include care that can be safely postponed until the Participant returns to the Plan Service Area to receive such care from a Plan Provider.

b. You must receive Urgent Care from a Plan Provider if you are in the Plan Service Area. If you are out of the Plan Service Area, go to the nearest appropriate medical facility unless you can safely return to the Plan Service Area to receive care from a Plan Provider.

c. Some examples of Urgent Care cases are:
   - Most Broken Bones
   - Minor Cuts
   - Sprains
   - Most Drug Reactions
   - Non-Severe Bleeding
   - Minor Burns

3. Surgical Services

Surgical procedures, wherever performed, when needed to care for disease and accidental injury. These include: (a) Preoperative and Postoperative care; and (b) needed services of assistants and consultants.

4. Reproductive Services

The following services do not require a referral to a Plan Provider who specializes in obstetrics and gynecology, however, the plan may require that the Participant obtain prior authorization for some services.

a. Maternity Services for prenatal and postnatal care, including services such as normal deliveries, ectopic pregnancies, Cesarean sections, therapeutic abortions, and miscarriages. Maternity benefits are also available for a daughter who is covered under this Plan as a Participant. In accordance with the federal Newborns' and Mother' Health Protection Act, the inpatient stay will be covered for 48 hours following a normal delivery and 96 hours following a cesarean delivery, unless a longer inpatient stay is Medically Necessary. A shorter hospitalization related to maternity and newborn care may be provided if the shorter stay is deemed appropriate by the attending physician in consultation with the mother.

b. Elective sterilization.

c. Oral contraceptives, as described under the Prescription Drug benefit.

d. IUDs and diaphragms, as described under the Durable Medical Equipment provision.

e. Medroxyprogesterone acetate injections for contraceptive purposes (e.g., Depo Provera).

If the Participant is in her second or third trimester of pregnancy when the provider's participation in the Plan terminates, the Participant will continue to have access to the provider until completion of postpartum care for the woman and infant.

5. Medical Services

Provided to inpatients and outpatients and those receiving home care services by an approved Provider of Health Care. This includes annual routine physical examinations, well-baby care and childhood immunizations and other immunizations as Medically Necessary. It also includes Medically Necessary travel-related preventive treatment when travel is not related to work or education. Preventive travel-related care includes typhoid, diphtheria, tetanus, yellow fever and Hepatitis A vaccinations if determined to be medically appropriate by the Plan.

6. Anesthesia Services

Covered when they are provided in connection with other medical and surgical services, which are covered under this Plan and performed by an approved Provider of Health Care. It will also include anesthesia services for dental care as provided under item B., 1., c., of this section.

7. Radiation Therapy

Covered when accepted therapeutic methods, such as x-rays, radium and radioactive isotopes are administered and billed by an approved Provider of Health Care.

8. Detoxification Services

Covers Medically Necessary detoxification services provided by an approved Provider of Health Care.

9. Ambulance Service

Covers established ambulance service (or comparable Emergency transportation if authorized by the Plan) to or from a Hospital when the conveyance is Emergent or Urgent in nature and medical attention is required en route, as described in the Schedule of Benefits. Ambulance services include medically necessary transportation and all associated supplies and services provided therein. If the Participant is not in the Plan's Service Area, the Plan or Plan Provider should be contacted, if possible, before Emergency or Urgent transportation is obtained. In most cases, medical attention should be received at the closest appropriate medical facility rather than returning to the Service Area for treatment.

10. Diagnostic Services

Medically Necessary testing and evaluations, including, but not limited to, x-rays and lab tests given with general physical examinations; vision and hearing tests to determine if correction is needed; annual routine mammography screening when ordered and performed by a Plan Provider, including nurse practitioners; and other covered services. Services of a nurse practitioner will be covered in connection with mammography screening, Papanicolaou tests and pelvic examinations.

11. Outpatient Physical, Speech and Occupation Therapy

Medically Necessary services as a result of illness or injury, provided by a Plan Provider. Therapists must be registered and must not live in the patient's home or be a family member. Limited to the benefit maximum described in the Schedule of Benefits, although up to 50 additional visits per therapy per contract year may be prior authorized by the Plan if the therapy continues to be Medically Necessary and is not otherwise excluded.

12. Home Care Benefits

Care and treatment of a Participant under a plan of care. The Plan Provider must establish this plan; approve it in writing; and review it at least every two (2) months unless the physician determines that less frequent reviews are sufficient.

All home care must be Medically Necessary as part of the home care plan. Home care means one or more of the following:

a. Home nursing care that is given part-time or from time to time. It must be given or supervised by a registered nurse.

b. Home health aide services that are given part-time or from time to time and are skilled in nature. They must consist solely of caring for the patient. A registered nurse or medical social worker must supervise them.

c. Physical, respiratory, occupational and speech therapy.

d. Medical supplies, drugs and medicines prescribed by a plan physician; and lab services by or for a Hospital. They are covered to the same extent as if the Participant was Hospital Confined.

e. Nutritional counseling. A registered dietician must give or supervise these services.

f. The assessment of the need for a home care plan, and its development. A registered nurse, physician extender or medical social worker must do this. The attending physician must ask for or approve this service.

   Home care will not be covered unless the attending physician certifies that:

   1) Hospital Confinement or Confinement in a Skilled Nursing Facility would be needed if home care were not provided.

   2) The Participant's Immediate Family, or others living with the Participant, cannot provide the needed care and treatment without undue hardship.

   3) A state licensed or Medicare certified home health agency or certified rehabilitation agency will provide or coordinate the home care.

A Participant may have been confined in a Hospital just before home care started. If so, the home care plan must be approved, at its start, by the physician who was the primary provider of care during the Hospital Confinement.

Home care benefits are limited to the maximum number of visits specified in the Schedule of Benefits, although up to 50 additional home care visits per contract year may be prior authorized by the Plan if the visits continue to be Medically Necessary and are not otherwise excluded. Each visit by a person providing services under a home care plan, evaluating your needs or developing a plan counts as one visit. Each period of four (4) straight hours in a twenty-four (24) hour period of home health aide services counts as one home care visit.

13. Hospice Care

Covers Hospice Care if the Primary Care Provider certifies that the Participant's life expectancy is 6 months or less, the care is palliative in nature, and is authorized by the Plan. Hospice care is provided by an inter-disciplinary team, consisting of but not limited to, registered nurses, home health or hospice aides, LPNs, and counselors. Hospice care includes, but is not limited to, medical supplies and services, counseling, bereavement counseling for 1 year after the Participant's death, durable medical equipment rental, home visits, and Emergency transportation. Coverage may be continued beyond a 6-month period if authorized by the Plan.

14. Phase II Cardiac Rehabilitation

Services must be approved by the Plan and provided in an outpatient department of a Hospital, in a medical center or clinic program. This benefit may be appropriate only for Participants with a recent history of: (a) a heart attack (myocardial infarction); (b) coronary bypass surgery; (c) onset of angina pectoris; (d) heart valve surgery; (e) onset of decubital angina; (f) onset of unstable angina; (g) percutaneous transluminal angioplasty; or (h) heart transplant. Benefits are not payable for behavioral or

vocational counseling. No other benefits for outpatient cardiac rehabilitation services are available under this contract.

15. Extraction of Natural Teeth and Replacement with Artificial Teeth Because of Accidental Injury

Total extraction or total replacement (i.e., bridge or denture) of natural teeth by an approved Plan Provider when necessitated by an injury. The treatment must occur within eighteen months of the accident. An alternative dental repair method, in lieu of extraction and replacement, may be considered if approved by the Plan before the service is performed (i.e., crowns or caps for broken teeth). Injuries caused by chewing or biting are not considered to be accidental injuries for the purpose of this provision.

16. Oral Surgery

Participants should contact the Plan prior to any oral surgery to determine if prior authorization by the Plan is required. When performed by Plan Providers, approved surgical procedures are as follows:

a. Surgical removal of impacted or infected teeth and erupted third molars.

b. Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth, when such conditions require a pathological examination.

c. Frenotomy. (Incision of the membrane connecting tongue to floor of mouth.)

d. Surgical procedures required to correct accidental injuries to the jaws, cheeks, lips, tongue, roof and floor of the mouth, when such injuries are incurred while the Participant is continuously covered under this contract or a preceding contract provided through the Board.

e. Apicoectomy. (Excision of apex of tooth root.)

f. Excision of exostoses of the jaws and hard palate.

g. Intraoral and extraoral incision and drainage of cellulitis.

h. Incision of accessory sinuses, salivary glands or ducts.

i. Reduction of dislocations of, and excision of, the temporomandibular joints.

j. Gingivectomy or osseous surgery and related guided tissue regeneration and bone-graft replacement, when performed in place of a gingivectomy and for the excision of loose gum tissue to eliminate infection.

k. Alveolectomy or alveoplasty (if performed for reasons other than preparation for dentures) and associated osseous (removal of bony tissue) surgery.

Retrograde fillings are covered when Medically Necessary following covered oral surgery procedures.

Oral surgery benefits shall not include benefits for procedures not listed above; for example, the extraction of teeth by pulling, root canal procedures, filling, capping or recapping.

17. Treatment of Temporomandibular Disorders

Covers diagnostic procedures and prior authorized Medically Necessary surgical or non- surgical treatment for the correction of temporomandibular disorders, if all of the following apply:

a. A congenital, developmental or acquired deformity, disease or injury caused the condition.

b. The procedure or device is reasonable and appropriate for the diagnosis or treatment of the condition under the accepted standards of the profession of the health care provider rendering the service.

c. The purpose of the procedure or device is to control or eliminate infection, pain, disease or dysfunction.

This includes coverage of non-surgical treatment, including intraoral splint therapy, but does not include coverage for cosmetic or elective orthodontic, periodontic or general dental care. Benefits for diagnostic procedures and non-surgical treatment will be payable up to $1250 per contract year.

18. Transplants

The following transplantations are covered, however, all services, including transplant work-ups, must be prior authorized by the Plan in order to be a covered transplant. Donor expenses are covered when included as part of the Participant's (as the transplant recipient) bill. All transplant-related expenses, including Preoperative and Postoperative care, are applied to the $500,000 maximum lifetime benefit.

Limited to one transplant per organ per Participant during the lifetime of the policy, except as required for treatment of kidney disease. Retransplantation is not a covered benefit.

a. Autologous (self to self) and allogeneic (donor to self) bone marrow transplantations, including peripheral stem cell rescue, used only in the treatment of:
   - Aplastic anemia
   - Acute leukemia
   - Severe combined immunodeficiency, e.g., adenosine deaminase deficiency and idiopathic deficiencies
   - Wiskott-Aldrich syndrome
   - Infantile malignant osteopetrosis (Albers-Schoenberg disease or marble bone disease)
   - Hodgkins and non-Hodgkins lymphoma
   - Combined immunodeficiency
   - Chronic myelogenous leukemia
   - Pediatric tumors based upon individual consideration
   - Neuroblastoma
   - Mydlodysplastic syndrome
   - Homozygous Beta-Thalassemia
   - Mucopolysaccharidoses (e. g. Gaucher's disease, Metachromatic Leukodystrophy, Adrenoleukodystrophy)
   - Multiple Myeloma, Stage II or Stage III
   - Germ Cell Tumors (e. g. testicular, mediastinal, retroperitoneal or ovarian) refractory to standard dose chemotherapy with FDA approved platinum compound

b. Parathyroid transplantation

c. Musculoskeletal transplantations intended to improve the function and appearance of any body area, which has been altered by disease, trauma, Congenital anomalies or previous therapeutic processes.

d. Corneal transplantation (keratoplasty) limited to:
   - Corneal opacity
   - Keratoconus or any abnormality resulting in an irregular refractive surface not correctable with a contact lens or in a Participant who cannot wear a contact lens;
   - Corneal ulcer
   - Repair of severe lacerations

e. Heart transplants will be limited to the treatment of:
   - Congestive Cardiomyopathy
   - End-Stage Ischemic Heart Disease
   - Hypertrophic Cardiomyopathy
   - Terminal Valvular Disease

- Congenital Heart Disease, based upon individual consideration
- Cardiac Tumors, based upon individual consideration
- Myocarditis
- Coronary Embolization
- Post-traumatic Aneurysm

f. Liver transplants will be limited to the treatment of:
- Extrahepatic Biliary Atresia
- Inborn Error of Metabolism
  - Alpha -1- Antitrypsin Deficiency
  - Wilson's Disease
  - Glycogen Storage Disease
  - Tyrosinemia
- Hemochromatosis
- Primary Biliary Cirrhosis
- Hepatic Vein Thrombosis
- Sclerosing Cholangitis
- Post-necrotic Cirrhosis, Hbe Ag Negative
- Chronic Active Hepatitis, Hbe Ag Negative
- Alcoholic Cirrhosis, abstinence for 12 or more months
- Epithelioid Hemangioepithelioma
- Poisoning
- Polycystic Disease

g. Kidney/pancreas, heart/lung, and lung transplants as determined to be Medically Necessary by the Plan.

h. In addition to the above-listed diagnoses for covered transplants, the Plan may prior authorize a transplant for a non-listed diagnosis if the Plan determines that the transplant is a Medically Necessary and a cost effective alternate treatment.

i. Kidney Transplants. See item 19. below.

19. Kidney Disease Treatment

Coverage for inpatient and outpatient kidney disease treatment will be provided. This benefit is limited to all services and supplies directly related to kidney disease, including but not limited to, dialysis, transplantation, donor-related services, and related physician charges.

20. Chiropractic Services

When performed by a Plan Provider. Benefits are not available for Maintenance Therapy.

21. Women's Health and Cancer Act of 1998

Under the Women's Health and Cancer Act of 1998, coverage for the treatment of breast cancer includes:
- Reconstruction of the breast on which a mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses and physical complications of all stages of mastectomy, including lymphedemas.

22. Smoking Cessation

Coverage includes pharmacological products that by law require a written prescription and are prescribed by a Plan Provider for the purpose of achieving smoking cessation (i.e., Zyban, nicotine inhaler, spray or patch). These are subject to the prescription drug copayment and annual out-of-pocket maximum. Limited to a maximum of one three-month course of pharmacotherapy per calendar year. Coverage also includes one office visit for counseling and to obtain the prescription. Additional counseling may be authorized by the Plan.

B. Institutional Services

Covers inpatient and outpatient Hospital services and Skilled Nursing Facility services that are necessary for the admission, diagnosis and treatment of a patient when provided by a Plan Provider. Each Participant in a health care facility agrees to conform to the rules and regulations of the institution. The Plan may require that the hospitalization be prior authorized.

1. Inpatient Care

a. Hospitals and Specialty Hospitals: Paid in full for semi-private room, ward or intensive care unit and Medically Necessary miscellaneous Hospital expenses. A private room is payable only if Medically Necessary for isolation purposes as determined by the Plan.

b. Licensed Skilled Nursing Facility: Must be admitted within twenty-four (24) hours of discharge from a general Hospital for continued treatment of the same condition. Care must be Skilled. Custodial care is excluded. Benefits limited to the number of days specified in the Schedule of Benefits. Confinement in a swing bed in a Hospital is considered the same as a Skilled Nursing Facility Confinement.

c. Hospital and Ambulatory Surgery Center Charges and related Anesthetics for Dental Care: Paid in full if services are provided to a Participant who is under five years of age; has a medical condition that requires hospitalization or general anesthesia for dental care; or has a chronic disability that meets all of the conditions under Wis. Stat. § 230.04 (9r) (a) 2. a., b., and c.

2. Outpatient Care

Emergency Care: First aid, accident or sudden illness requiring immediate Hospital services. Subject to the Copayment described in the Schedule of Benefits. Follow-up care received in an emergency room to treat the same injury is also subject to the Copayment.

Mental Health/Alcohol and Drug Abuse Services: See below for benefit details.

Diagnostic Testing: Includes chemotherapy, laboratory, x-ray, and other diagnostic tests.

Surgical Care: Paid in full.

C. Other Medical Services

1. Mental Health Services/Alcohol and Drug Abuse

a. Outpatient Services

Covers Medically Necessary services provided by a Plan Provider as described in the Schedule of Benefits. The outpatient services means non-residential services by providers as defined and set forth under Wis. Stat. § 632.89 (1) (e).

This benefit also includes services for a full-time student attending school in Wisconsin but out of the Plan Service Area as required by Wis. Stat. § 609.655.

b. Transitional Services

Covers Medically Necessary services provided by a Plan Provider as described in the Schedule of Benefits. Transitional Care is provided in a less restrictive manner than inpatient services but in a more intensive manner than outpatient services as required by Wis. Stat. § 632.89. The transitional care must be prior authorized by the Plan.

c. Inpatient Services

Covers Medically Necessary services provided by a Plan Provider as described in the Schedule of Benefits and as required by Wis. Stat. §632.89. Covers court-ordered services for the mentally ill as

required by Wis. Stat. § 609.65. Such services are covered if performed by a Non-Plan Provider, if provided pursuant to an Emergency detention or on an Emergency basis and the provider notifies the Plan within 72 hours after the initial provision of service.

d. Other

1) Prescription drugs used for the treatment of mental health, alcohol and drug abuse will be subject to the prescription drug benefit. The charges for such drugs will not be applied the maximum benefit available for any mental health, alcohol or drug abuse services.

2) The dollar amounts applied to the maximum benefits available for the treatment of mental health, alcohol, and drug abuse will be based upon the average amount paid to the provider by the Plan.

2. Prescription Drugs

Coverage includes legend drugs and biologicals which by law require a written prescription; are prescribed by a Plan Provider for treatment of a diagnosed illness or injury; and are purchased from a Plan Pharmacy after a Copayment amount, as described in the Schedule of Benefits. A Copayment will be applied to each prescription dispensed, but no less than one Copayment for each thirty (30) consecutive day supply.

An annual out-of-pocket maximum applies to Participants' Copayments for covered prescription drugs. When any Participant pays $300 out-of-pocket in prescription drug Copayments, that Participant's covered prescriptions will be paid in full for the rest of the contract year. Further, if participating family members combined have paid $600 in a year, even if no one Participant has paid $300 in Copayments, all family members will have satisfied the annual out-of-pocket maximum for that contract year. The Participant's cost for non-covered prescription drugs will not be applied to the annual out-of-pocket maximum. If the cost of a prescription drug is less than the applicable Copayment, the Participant will pay only the actual cost and that amount will be applied to the annual out- of-pocket maximum.

Prescription drugs will be dispensed as follows:

- in maximum quantities not to exceed a thirty (30) consecutive day supply per Copayment for brand name and generic substitutes.
- single packaged items are limited to 2 items per Copayment or a thirty (30)-day supply, whichever is more appropriate.
- generic substitutes will be dispensed unless the Plan Provider specifies the brand name prescription and indicates that no substitutions may be made or the brand drug has been prior authorized by the Plan.
- non-Formulary drugs will be dispensed if Medically Necessary and the Formulary drugs are not suitable for the Participant. Non-Formulary drugs must be prior authorized by the Plan or they will not be covered. The Formulary may be revised as deemed necessary by the Plan.
- drugs purchased in connection with Emergency or Urgent Care services are not required to be purchased from a Plan Pharmacy if it is not reasonable to comply with that requirement.
- Oral Contraceptives are not subject to the thirty (30) day supply and will be dispensed at one copay per package.

Some prescription drugs may only be dispensed by a Plan Pharmacy after receiving prior authorization from the Plan.

This coverage includes investigational drugs for the treatment of HIV, as required by Wis. Stat. § 632.895 (9).

3. Insulin and Durable and Disposable Diabetic Supplies

Insulin is covered as a prescription drug. Insulin will be dispensed in a maximum quantity of a thirty-four (34) consecutive day supply for one prescription drug Copayment, as described on the Schedule of Benefits.

When prescribed by a Plan Provider for treatment of diabetes and purchased from a Plan Provider for Durable or Disposable Diabetic Supplies, the following items will be covered after a 20% Coinsurance as outlined in the Schedule of Benefits:

- Disposable diabetic supplies including needles, syringes, alcohol swabs, lancets, lancing devices, blood or urine test strips, disposable supplies required for the use of durable diabetic equipment. The Participant's Coinsurance will be applied to the annual out-of-pocket maximum for prescription drugs.

- Durable diabetic equipment including Accucheks, glucometers, insulin infusion pump (limited to one pump in a calendar year and you must use the pump for thirty 30 days before purchase). Automated injection devices are covered if prior authorized by the Plan. The Participant's Coinsurance will be applied to the annual out-of-pocket maximum for durable medical equipment.

  All durable medical equipment purchases or monthly rentals that exceed $200.00 must be prior authorized by the Plan.

4. Medical Supplies and Durable Medical Equipment

When prescribed by a Plan Provider for treatment of a diagnosed illness or injury and purchased from a Plan Provider for Medical Equipment after a Coinsurance as outlined in the Schedule of Benefits. All durable medical equipment purchases or monthly rentals that exceed $200.00 must be prior authorized by the Plan. The following supplies and equipment will be covered:

- Initial acquisition of artificial limbs or eyes or as needed for growth and development.

- Casts, splints, trusses, crutches, orthopedic braces and appliances and custom-made orthotics.

- Rental or, at the option of the Plan, purchase of equipment such as, but not limited to: wheelchairs, hospital-type beds, and artificial respiration equipment.

- Therapeutic contact lenses or an initial lens(es) per surgical eye following cataract surgery.

- IUDs and diaphragms.

- Elastic support hose, e.g., JOBST, which are prescribed by a Plan Provider. Limited to two pairs per contract year.

- One hearing aid per ear every three years, up to a maximum of $1000 per hearing aid. The annual out-of-pocket maximum for Durable Medical Equipment does not apply to this benefit.

- Other medical equipment and supplies as approved by the Plan. Rental or purchase of equipment/supplies is at the option of the Plan.

- Repairs, maintenance and replacement of covered durable medical equipment/supplies if prior authorized by the Plan, including replacement of batteries. When determining whether to repair or replace the durable medical equipment/supplies, the Plan will consider whether: i) the equipment/supply is still useful or has exceeded its lifetime under normal use; or ii) the Participant's condition has significantly changed so as to make the original equipment inappropriate (e.g., due to growth or development).

5. Out-of-Plan Coverage For Full-Time Students

If a Dependent is a full-time student attending school outside of the HMO Service Area, the following services will be covered:

a. Emergency or Urgent Care. Follow-up care out of the Service Area must be prior authorized; and

b. Outpatient mental health services and treatment of alcohol or drug abuse if the Dependent is a full-time student attending school in Wisconsin, but outside of the Plan Service Area. In that case, the Dependent may have a clinical assessment by a Non-Plan Provider that the Plan designates. If outpatient services are recommended, coverage will be provided for five (5) visits outside of the Plan's Service Area. Additional visits may be approved by the Plan. If the student is unable to maintain full-time student status, he/she must return to the Plan's Service Area for the treatment to be covered. This benefit is subject to the dollar limitation shown in the Schedule of Benefits for mental health/alcohol/drug abuse services and will not serve to provide additional benefits to the Participant.

6. Congenital Defects and Birth Abnormalities

If a Dependent is continuously covered under this health insurance program from birth, coverage includes treatment for the functional repair or restoration of any body part when necessary to achieve normal functioning, as required by Wis. Stat. § 632.895 (5) and Wis. Adm. Code § INS 3.38 (2) (d). Orthodontia and dental procedures are covered if necessary for restoration of normal functioning or in preparation for surgery to restore function.

IV. EXCLUSIONS AND LIMITATIONS

A. Exclusions

The following is a list of services, treatments, equipment or supplies that are excluded (meaning no benefits are payable under the Plan Benefits); or have some limitations on the benefit provided. Some of the listed exclusions may be medically necessary, but still are not covered under this plan, while others may be examples of services which are not Medically Necessary or not medical in nature, as determined by the Plan.

1. Surgical Services

a. Procedures, services, and supplies related to sex transformation surgery and sex hormones related to such treatments.

b. Treatment, services and supplies for cosmetic or beautifying purposes, except when associated with a covered service to correct Congenital bodily disorders or conditions or when associated with covered reconstructive surgery due to an illness or accidental injury (including subsequent removal of a prosthetic device that was related to such reconstructive surgery). Psychological reasons do not represent a medical/surgical necessity.

c. Any surgical treatment or Hospitalization for the treatment of obesity, including morbid obesity.

d. Keratorefractive eye surgery, including but not limited to, tangential or radial keratotomy, or laser surgeries for the correction of vision.

2. Medical Services

a. Examination for informational purposes requested by third parties. Examples are physical exams for employment, licensing, insurance, marriage, adoption, participation in athletics, or examinations or treatment ordered by a court, unless otherwise covered as stated in the Benefits section.

b. Expenses for medical reports, including preparation and presentation.

c. Services rendered (a) in the examination, treatment or removal of all or part of corns, calluses, hypertrophy or hyperplasia of the skin or subcutaneous tissues of the feet; (b) in the cutting, trimming or other nonoperative partial removal of toenails; (c) treatment of flexible flat feet; or (d) in connection with any of these except when prescribed by a Plan Provider who is treating the Participant for a metabolic or peripheral disease or if the skin or tissue is infected.

d. Weight loss programs including dietary and nutritional treatment in connection with obesity.

e. Work or education related preventive treatment (e.g., Hepatitis vaccinations, Rabies vaccinations, etc.). This exclusion does not apply to Medically Necessary travel-related preventive care when the travel is not related to work or education.

f. Services of a blood donor. Medically Necessary autologous blood donations are not considered to be services of a blood donor.

3. Ambulance Services

a. Ambulance service, except as outlined in the Benefits and Services section, unless authorized by the Plan.

b. Charges for, or in connection with, travel, except for ambulance transportation as outlined in the Benefits Section.

4. Therapies

a. Vocational rehabilitation including work hardening programs.

b. Maintenance therapy. Examples include: physical, speech and occupational therapy and other special therapy except as specifically listed in the Benefits section.

c. Therapies, as determined by the Plan, for the evaluation, diagnosis or treatment of educational problems. Some examples of the type of assessments and therapies which are not covered are: educational programs, developmental and neuro-educational testing and treatment, second opinions on school or educational assessments of any kind, including physical therapy, speech therapy, occupational therapy and all hearing treatments for the conditions listed herein.

   The therapies that are excluded may be used to treat conditions such as learning/developmental disabilities, communication delays, perceptual disorders, mental retardation, behavioral disorders, hyperactivity, attention deficit disorders, minimal brain dysfunction, sensory deficits, multiple handicaps, and motor dysfunction.

d. Physical fitness or exercise programs.

e. Biofeedback, except that provided by a physical therapist for treatment of headaches and spastic torticollis.

5. Oral Surgery/Dental Services/Extraction and Replacement Because of Accidental Injury

a. All services performed by dentists and other dental services, including all orthodontic services, except those specifically listed in the Benefits Section or which would be covered if it was performed by a physician and is within the scope of the dentist's license. This includes, but is not limited to, dental implants; shortening of the mandible or maxillae; correction of malocclusion; and hospitalization costs for services not specifically listed in the Benefits Section.

b. All periodontic procedures, except gingivectomy surgery as listed in the Benefits Section.

c. All oral surgical procedures not specifically listed in the Benefits Section.

6. Transplants

a. Transplants and all related services, except those listed as covered procedures.

b. Services in connection with covered transplants unless prior authorized by the Plan.

c. Retransplantation or any other costs related to a failed transplant that is otherwise covered under the global fee. Only one transplant per organ per Participant is covered during the lifetime of the policy, except as required for treatment of kidney disease.

d. Purchase price of bone marrow, organ or tissue that is sold rather than donated.

e. All separately billed donor-related services, except for kidney transplants.

f. Non-human organ transplants or artificial organs.

7. Reproductive Services

a. Infertility services which are not for treatment of illness or injury (i.e., which are for the purpose of achieving pregnancy). The diagnosis of infertility alone does not constitute an illness.

b. Reversal of voluntary sterilization procedures and related procedures when performed for the purpose of restoring fertility.

c. Donor Sperm.

d. Artificial insemination or fertilization methods including, but not limited to, in vivo fertilization, in vitro fertilization, embryo transfer, gamete intra fallopian transfer (GIFT) and similar procedures, and related Hospital, professional and diagnostic services and medications that are incidental to such insemination or fertilization methods.

e. Implantable birth control devices (e.g., Norplant).

f. Surrogate mother services.

g. Maternity services received out of the Plan Service Area in the ninth month of pregnancy, unless prior authorized (Prior authorization will be granted only if the situation is out of the Participant's control (e.g., family emergency).

h. Amniocentesis or chorionic villi sampling (CVS) solely for sex determination.

8. Hospital Inpatient Services

a. Take home drugs and supplies dispensed at the time of Hospital discharge, which can reasonably be purchased on an outpatient basis.

b. Hospital stays, which are extended for reasons other than Medical Necessity, i.e. lack of transportation, lack of caregiver, inclement weather and other, like reasons.

c. A continued Hospital stay, if the attending physician has documented that care could effectively be provided in a less acute care setting, e.g., Skilled Nursing Facility.

9. Mental Health Services

a. Hypnotherapy.

b. Marriage counseling.

c. Residential care.

d. Biofeedback.

10. Outpatient Prescription Drugs

a. Charges for supplies and medicines you buy with or without a doctor's prescription, except those in connection with mandated home health care, unless otherwise specifically covered.

b. Charges for prescription drugs which require prior authorization unless approved by the Plan.

c. Charges for cosmetic Retin-A, Rogaine, or their medical equivalent, appetite suppressants, non-FDA approved oral progesterone and all over the counter drug items, except nicotinic acid.

d. Unit dose medication, except for medications that are unavailable in any other dose or packaging.

e. Charges for injectable medications administered in a nursing home when the nursing home stay is not covered by the Plan.

f. Drugs recently approved by the FDA may be excluded until reviewed and approved by the Plan's Pharmacy and Therapeutics Committee which determines the therapeutic advantage of the drug and the medically appropriate application.

11. Durable Medical or Diabetic Equipment and Supplies

a. All durable medical equipment purchases or rentals per month exceeding $200 unless authorized by the Plan.

b. Repairs and replacement of durable medical equipment/supplies unless prior authorized by the Plan.

c. Medical supplies and durable medical equipment for comfort, personal hygiene and convenience items such as, but not limited to, air conditioners, air cleaners, humidifiers; or physical fitness equipment, physician's equipment; disposable supplies; alternative communication devices; and self-help devices not medical in nature.

d. Home testing and monitoring supplies and related equipment except those used in connection with the treatment of diabetes or infant apnea or as prior authorized by the Plan.

e. Equipment, models or devices which have features over and above that which are Medical Necessary for the Participant will be limited to the standard model as determined by the Plan.

f. Oxygen therapy and other inhalation therapy and related items for home use except as authorized by the Plan.

g. Motor vehicles (e.g., cars, vans) or customization of vehicles, lifts for wheel chairs and scooters, and stair lifts.

12. General

a. Any additional exclusion as described in the Schedule of Benefits.

b. Services to the extent the Participant is eligible for Medicare benefits, regardless of whether or not the Participant is actually enrolled in Medicare. This exclusion only applies if Medicare is the primary payor.

c. Injury or illness caused by: (a) Atomic or thermonuclear explosion or resulting radiation; or (b) any type of military action, friendly or hostile.

d. Treatment, services and supplies: (a) for which the Participant has no obligation to pay or which would be furnished to a Participant without charge; (b) which a Participant would be entitled to have furnished or paid for, fully or partially, under any law, regulation or agency of any government; or (c) which a Participant would be entitled, or would be entitled if enrolled, to have furnished or paid for under any voluntary medical benefit or insurance plan established by any government; if this contract was not in effect.

e. Treatment, services and supplies for any injury or illness as the result of war, declared or undeclared, enemy action or action of Armed Forces of the United States, or any State of the United States, or its Allies, or while serving in the Armed Forces of any country.

f. Treatment, services and supplies furnished by the U.S. Veterans Administration, except for such treatment, services and supplies for which under the policy the Plan is the primary payor and the U.S. Veterans Administration is the secondary payor under applicable federal law.

g. Services for holistic medicine, including homeopathic medicine, or other programs with an objective to provide complete personal fulfillment.

h. Treatment, services or supplies used in educational or vocational training.

i. Expenses related to planned medical or surgical treatment which the Participant subsequently refuses against medical advice.

j. Treatment or service in connection with any illness or injury caused by a Participant (a) engaging in an illegal occupation or (b) commission of, or attempt to commit, a felony.

k. Care provided to assist with activities of daily living (ADL).

l. Personal comfort or convenience items such as in-Hospital television, telephone, private room, housekeeping, shopping, and homemaker services, and meal preparation services as part of home health care.

m. Custodial, nursing facility (except skilled), or domiciliary care. This includes community re-entry programs.

n. Expenses incurred, or inpatient Confinements which begin prior to the coverage Effective Date in the Plan, or services received after the Plan coverage or eligibility terminates. Except when a Participant's coverage terminates because of cancellation or non-payment of premium, benefits shall continue to the Participant if he or she is Confined as an inpatient on the coverage termination date, but only until the attending physician determines that Confinement is no longer Medically Necessary; the contract maximum is reached; the end of 12 months after the date of termination; or Confinement ceases, whichever occurs first.

o. Eyeglasses and contact lenses, fitting of contact lenses, except for one lens per surgical eye after cataract surgery.

p. Any service, treatment, procedure, equipment, drug, device or supply which is not reasonably and Medically Necessary or not required in accordance with accepted standards of medical, surgical or psychiatric practice.

q. Charges for any missed appointment.

r. Experimental services, treatments, procedures, equipment, drugs, devices or supplies, including, but not limited to: Treatment or procedures not generally proven to be effective as determined by the Plan following review of research protocol and individual treatment plans; orthomolecular medicine, acupuncture, cytotoxin testing in conjunction with allergy testing, hair analysis except in conjunction with lead and arsenic poisoning. Phase I, II and III protocols for cancer treatments and certain organ transplants. In general, any service considered to be Experimental, except drugs for treatment of an HIV infection, as required by Wis. Stat. § 632.895 (9).

s. Services provided by members of the Subscriber's Immediate Family or any person residing with the Subscriber.

t. Services, including non-physician services, provided by Non-Plan Providers of Health Care. Exceptions to this exclusion:

    1) On written Referral by the Primary Care Physician with the prior written authorization of the Plan.

    2) Emergencies in the Service Area when the Primary Care Provider or another Plan Provider cannot be reached.

    3) Emergency or urgent care services outside the Service Area.

u. Services of a specialist without a Plan Provider's written Referral, except in an Emergency or by written prior authorization of the Plan. Any Hospital or medical care or service not provided for in this document unless authorized by the Plan.

v. Coma Stimulation programs.

w. Orthoptics (Eye exercise training) except for two sessions as medically necessary. The first session for training, the second for follow up.

x. Any weight reduction or diet control program, treatment, or supply.

y. Food received on an outpatient basis or food supplements.

z. Services to the extent a Participant receives or is entitled to receive, any benefits, settlement, award or damages for any reason of, or following any claim under, any Worker's Compensation act, employer's liability insurance plan or similar law or act. Entitled means you are actually insured under Worker's Compensation.

aa. Services related to an injury that was self-inflicted for the purpose of receiving Plan Benefits.

ab. Charges directly related to a non-covered service, such as hospitalization charges. Medically Necessary treatment of a complication that could not be reasonably expected is covered when performed by a Plan Provider or when authorized by the Plan in Emergency situations. The treatment of the complication must be a covered benefit of the plan.

ac. Any inpatient Confinement that begins prior to the Participant's initial enrollment under the Board's program is not covered. Such inpatient Confinement will not be covered under any subsequent plan in which the Participant becomes enrolled.

ad. Any smoking cessation program, treatment, or supply that is not specifically covered in the Benefits section.

B. Limitations

1. Copayments or Coinsurance are required for, and/or limitations apply to, the following services: Outpatient Services/Mental Health Services/Alcohol and Drug Abuse, Durable Medical Equipment, Prescription Drugs, Smoking Cessation, Ambulance transportation and care received in an emergency room.

2. Benefits are limited for the following services: Replacement of Natural Teeth because of accidental injury, Oral Surgery, Hospital Inpatient, licensed Skilled Nursing Facility, Physical, Speech and Occupational Therapy, Home Care Benefits and Transplants.

3. Use of Non-plan Providers and Hospitals requires prior written approval by the Participant's Primary Care Provider and the Plan to determine medical appropriateness and whether services can be provided by Plan Providers.

4. Major Disaster or Epidemic: If a major disaster or epidemic occurs, Plan Providers and Hospitals render medical services (and arrange extended care services and home health service) insofar as practical according to their best medical judgment, within the limitation of available facilities and personnel, but neither the Plan nor any Plan Provider has any liability or obligation for delay or failure to provide or arrange any such services to the extent the disaster or epidemic causes unavailability of facilities or personnel. In this case, Participants may receive covered services from Non-plan Providers.

5. Circumstances Beyond the Plan's Control: If, due to circumstances not reasonably within the control of the Plan, such as a complete or partial insurrection, labor disputes not within the control of the Plan, disability of a significant part of Hospital or medical group personnel or similar causes, the rendition or provision of services and other benefits covered hereunder is delayed or rendered impractical, the Plan, and Plan Providers will use their best efforts to provide services and other Benefits covered hereunder, but neither the Plan nor any Plan Provider shall have any other liability or obligation on account of such delay or such failure to provide services or other benefits.

6. Speech and Hearing Screening Examinations: Limited to the routine screening tests performed by a Plan Provider for determining the need for correction.

7. Outpatient Physical, Occupational, Speech and Rehabilitation Therapy: These therapies are benefits only for treatment of those conditions which, in the judgment of the attending physicians, are expected to yield significant patient improvement within two months after the beginning of treatment.

8. Sexual Counseling Services: Limited to those techniques commonly used by Plan Providers and for conditions producing significant physical and mental symptoms.

9. Lifetime policy maximum for transplant benefits: $500,000.

   Only one transplant per organ per Participant is covered during the lifetime of the policy, except as required for treatment of kidney disease.

10. Lifetime maximum benefits under this policy: $2,000,000 (includes transplant benefits).

V. COORDINATION OF BENEFITS AND SERVICES

A. Applicability

1. This Coordination of Benefits ("COB") provision applies to This Plan when a Participant has health care coverage under more than one Plan at the same time. "Plan" and "This Plan" are defined below.

2. If this COB provision applies, the order of benefit determination rules shall be looked at first. The rules determine whether the benefits of This Plan are determined before or after those of another plan. The benefits of This Plan:

   a. shall not be reduced when, under the order of benefit determination rules, This Plan determines its benefits before another Plan; but

   b. may be reduced when, under the order of benefit determination rules, another Plan determines its benefits first. This reduction is described in Section D below, Effect on the Benefits of the Plan.

B. Definitions

1. "Allowable Expense" means a necessary, reasonable, and customary item of expense for health care, when the item of expense is covered at least in part by one or more Plans covering the person for whom the claim is made.

   The difference between the cost of a private Hospital room and the cost of a semi-private Hospital room is not considered an Allowable Expense unless the patient's stay in a private Hospital room is medically necessary either in terms of generally accepted medical practice or as specifically defined by the Plan.

   When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered shall be considered both an Allowable Expense and a benefit paid.

   However, not withstanding the above, when there is a maximum benefit limitation for a specific service or treatment, the secondary plan will also be responsible for paying up to the maximum benefit allowed for its plan. This will not duplicate benefits paid by the primary plan.

2. "Claim Determination Period" means a calendar year. However, it does not include any part of a year during which a person has no coverage under This Plan or any part of a year before the date this COB provision or a similar provision takes effect.

3. "Plan" means any of the following, which provides benefits or services for, or because of, medical or dental care or treatment:

   a. Group insurance or group-type coverage, whether insured or uninsured, that includes continuous 24-hour coverage. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.

   b. Coverage under a governmental plan or coverage that is required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act as amended from time to time). It also does not include any plan whose benefits, by law, are excess to those of any private insurance program or other non-governmental program.

   Each contract or other arrangement for coverage under a. or b. is a separate Plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.

4. "Primary Plan"/"Secondary Plan": The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another Plan covering the person.

   When This Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits.

   When This Plan is a Primary plan, its benefits are determined before those of the other Plan and without consideration of the other Plan's benefits.

   When there are more than two Plans covering the person, This Plan may be a Primary plan as to one or more other Plans and may be a Secondary Plan as to a different Plan or Plans.

5. "This Plan" means the part of your group policy that provides benefits for health care expenses.

C. Order Of Benefit Determination Rules

1. General

When there is a basis for a claim under This Plan and another plan, This Plan is a Secondary Plan, which has, its benefits determined after those of the other Plan. However, this Plan will be the primary Plan when:

a. the other Plan has rules coordinating its benefits with those of This Plan; and

b. both those rules and This Plan's rules described in subparagraph 2 require that This Plan's benefits be determined before those of the other Plan.

2. Rules

This Plan determines its order of benefits using the first of the following rules which applies:

a. Non-Dependent/Dependent

   The benefits of the Plan, which covers the person as an employee or participant, are determined before those of the Plan, which covers the person as a Dependent of an employee or participant.

b. Dependent Child/Parents Not Separated or Divorced

   Except as stated in subparagraph 2.c. below, when This Plan and another Plan cover the same child as a dependent of different persons, called "parents":

   1) the benefits of the Plan of the parent whose birthday falls earlier in the calendar year are determined before those of the Plan of the parent whose birthday falls later in that calendar year; but

   2) if both parents have the same birthday, the benefits of the Plan, which covered the parent longer, are determined before those of the Plan, which covered the other parent for a shorter period of time.

      However, if the other Plan does not have the rule described in (1) but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan shall determine the order of benefits.

c. Dependent Child/Separated or Divorced Parents

   If two or more Plans cover a person as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:

1) first, the Plan of the parent with custody of the child;

2) then, the Plan of the spouse of the parent with the custody of the child; and

3) finally, the Plan of the parent not having custody of the child.

Also, if the specific terms of a court decree state that the parents have joint custody of the child and do not specify that one parent has responsibility for the child's health care expenses or if the court decree states that both parents shall be responsible for the health care needs for the child but gives physical custody of the child to one parent and the entities obligated to pay or provide benefits of the respective parents' Plans have actual knowledge of those terms, benefits for the Dependent child shall be determined according to C.2.b.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. This paragraph does not apply with respect to any Claim Determination Period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

d. Active/Inactive Employee

The benefits of a Plan which covers a person as an employee who is neither laid off nor retired or as that employee's Dependent are determined before those of a Plan which covers that person as laid off or retired employee or as that employee's Dependent. If the other Plan does not have this rule and if, as a result, the Plans do not agree on the order of benefits, this rule d. is ignored.

e. Continuation Coverage

If a person has continuation coverage under federal or state law and is also covered under another plan, the following shall determine the order of benefits:

1) First, the benefit of a plan covering the person as an employee, member, or subscriber or as a Dependent of an employee, member, or subscriber.

2) Second, the benefits under the continuation coverage.

3) If the other plan does not have the rule described in subparagraph (1), and if as a result, the plans do not agree on the order of benefits, this paragraph e. is ignored.

f. Longer/Shorter Length of Coverage

If none of the above rules determines the order of benefits, the benefits of the Plan, which covered an employee, member or subscriber longer are determined before those of the Plan which covered that person for the shorter time.

D. Effect On The Benefits Of The Plan

1. When This Section Applies

This Section D. applies when, in accordance with Section C., Order of Benefit Determination Rules, This Plan is a secondary Plan as to one or more other Plans. In that event the benefits of This Plan may be reduced under this section. Such other Plan or Plans are referred to as "the other Plans" in 2.

2. Reduction in This Plan's Benefits

The benefits of this Plan will be reduced when the sum of the following exceeds the Allowable Expenses in a Claim Determination Period:

a. the benefits that would be payable for the Allowable Expenses under This Plan in the absence of the COB provision; and

b. the benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made. Under this provision, the benefits of This Plan will be reduced so that they and the benefits payable under the other plans do not total more than those Allowable Expenses.

When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

E. Right To Receive And Release Needed Information

The Plan has the right to decide the facts if needs to apply these COB rules. It may get needed facts from or give them to any other organization or person without the consent of the insured but only as needed to apply these COB rules. Medical records remain confidential as provided by state law. Each person claiming benefits under This Plan must provide any facts needed to pay the claim.

F. Facility Of Payment

A payment made under another Plan may include an amount which should have been paid under This Plan. If it does, This Plan may pay that amount to the organization which made that payment. That amount will then be treated as though it was a benefit paid under This Plan. This Plan will not have to pay that amount again. The term "payment made" means reasonable cash value of the benefits provided in the form of services.

G. Right Of Recovery

If the amount of the payments made by this Plan is more than it should have paid under this COB provision, it may recover the excess, at its option, from one or more of:

1. the persons it has paid or for whom it has paid;

2. insurance companies; or

3. other organizations.

The "amount of payments made" includes the reasonable cash value of any benefits provided in the form of services. A pre-existing condition limitation may apply.

VI. MISCELLANEOUS PROVISIONS

A. Right To Exchange Information

Each Participant agrees that the Plan, the Plan Provider and/or the Clinic may obtain from and provide to any person or organization (including, without limitation, internal and external medical review bodies) all information (including medical records) with respect to him/her where such information is reasonably necessary and appropriate to administer the Plan. Each Participant agrees, when requested by the Plan, Plan Provider, or the Clinic, to provide the Plan with information within his/her possession or control and authorizes and directs any person or institution that has attended, examined, or treated him/her to furnish the Plan at any reasonable time, and from time to time, upon its request, any and all information and records or copies of records relating to attendance, examination or treatment rendered to such Participant. By execution of an application for coverage under this Plan, each Participant shall be deemed to have waived any claims of privilege or confidentiality with respect to such information when released or obtained for the purposes described herein.

B. Physician And Hospital Reports

Physicians and Hospitals must give the Plan reports to help the Plan determine contract benefits due you. You agree to cooperate with the Plan to execute releases which authorize physicians, Hospitals and other providers of service to release all records to the Plan regarding services you receive. This is a condition of the Plan issuing the contract. It is also a condition of the Plan paying Benefits. All information must be furnished to the extent the Plan deems it necessary in a particular situation and as allowed by pertinent statues.

C. Physical Examination

The Plan, at its own expense, shall have the right and opportunity to examine the person of any Participant when and so often as may be reasonably necessary to determine his/her eligibility for claimed services or benefits under this Plan (including, without limitation, issues relating to subrogation and coordination of benefits). By execution of an application for coverage under the Plan, each Participant shall be deemed to have waived any legal rights he/she may have to refuse to consent to such examination when performed or conducted for the purposes set forth above.

D. Case Management/Alternate Treatment

The Plan employs a professional staff to provide case management services. As part of this case management, the Plan reserves the right to direct treatment to the most cost effective and clinically appropriate option available.

If the recommended treatment includes services for which benefits are not otherwise payable (e.g., biofeedback, acupuncture), payment of benefits will be as determined by the Plan.

E. Disenrollment

No person other than a Participant is eligible for health insurance benefits. The Subscriber's rights to group health insurance coverage is forfeited if a Participant assigns or transfers such rights, or aids any other person in obtaining benefits to which they are not entitled, or otherwise fraudulently attempts to obtain benefits. Coverage terminates the beginning of the month following action of the Board. Re-enrollment is possible only if the person is employed by an employer where the coverage is available and is limited to the Standard Plan with a 180-day waiting period for pre-existing conditions.

Change to an alternate plan via dual-choice enrollment is available during a regular dual-choice enrollment period, which begins a minimum of 12 months after the disenrollment date.

The Department may at any time request such documentation as it deems necessary to substantiate Subscriber or Dependent eligibility. Failure to provide such documentation upon request shall result in the suspension of benefits.

In situations where a Participant has committed acts of physical or verbal abuse, or is unable to establish/maintain a satisfactory physician-patient relationship with the current or alternate primary care physician, disenrollment efforts may be initiated by the Plan or the Board. The Subscriber's disenrollment is the beginning of the month following completion of the grievance process and approval of the Board. Coverage may be transferred to the Standard Plan only, with options to enroll in alternate health care plans during subsequent dual-choice enrollment periods. Re-enrollment in the Plan is available during a regular dual-choice enrollment period that begins a minimum of 12 months after the disenrollment date.

F. Advance Directives

If you are over age 18 and of sound mind, you may execute a living will or durable power of attorney for health care. The documents tell others what your wishes are if you are physically or mentally unable to express your wishes in the future. If you do have an advance directive, a copy should be given to your Primary Care Provider. Also, please notify the Plan in writing as the Plan is required, by law, to advise your Primary Care Provider and Clinic that you have one. You do not need to send the forms to the Plan. For more information, you should discuss the advance directives with your Primary Care Provider or Clinic or you can contact the Plan's customer service department.

G. Limitations On Suits

No action can be brought against the Plan to pay benefits until the earlier of: (1) Sixty (60) days after the Plan has received or waived proof of loss; or (2) the date the Plan has denied full payment. This delay will not ever cause prejudice against you. No action can be brought more than three (3) years after the time the Plan required written proof of loss.

H. Recovery Of Excess Payments

The Plan might pay more than the Plan owes under the policy. If so, the Plan can recover the excess from you. The Plan can also recover from another insurance company or service plan, or from any other person or entity that has received any excess payment from the Plan.

I. Limit On Assignability Of Benefits

This is your personal policy. You cannot assign any benefit to other than a physician, Hospital or other provider entitled to receive a specific benefit for you.

J. Severability

If any part of the policy is ever prohibited by law, it will not apply any more. The rest of the policy will continue in full force.

K. Subrogation

Each Participant agrees that the Plan shall be subrogated to a Participant's rights to damages, to the extent of the benefits the Plan provides under the policy, for illness or injury a third party caused or is liable for. It is only necessary that the illness or injury occur through the act of a third party. The Plan's rights of full recovery may be from any source, including but not limited to:

- The third party or any liability or other insurance covering the third party
- The Participant's own uninsured motorist insurance coverage
- Under-insured motorist insurance coverage
- Any medical payments, no-fault or school insurance coverages which are paid or payable.

Participant's rights to damages shall be, and they are hereby, assigned to the Plan to such extent.

The Plan subrogation rights shall not be prejudiced by any Participant. Entering into a settlement or compromise arrangement with a third party without the Plan's prior written consent shall be deemed to prejudice the Plan's rights. Each Participant shall promptly advise the Plan in writing whenever a claim against another party is made on behalf of a Participant and shall further provide to the Plan such additional information as is reasonably requested by the Plan. The Participant agrees to fully cooperate in protecting

the Plan's rights against a third party. The Plan has no right to recover from a Participant or insured who has not been "made whole" (as this term has been used in reported Wisconsin court decisions), after taking into consideration the Participant's or insured's comparative negligence. If a dispute arises between the Plan and the Participant over the question of whether or not the Participant has been "made whole", the Plan reserves the right to a judicial determination whether the insured has been "made whole".

In the event the Participant can recover any amounts, for an injury or illness for which the Plan provides benefits, by initiating and processing a claim pursuant to a workmen's or worker's compensation act, disability benefit act, or other employee benefit act, the Participant shall either assert and process such claim and immediately turn over to the Plan the net recovery after actual and reasonable attorney fees and expenses, if any, incurred in effecting the recovery, or, authorize the Plan in writing to prosecute such claim on behalf of the and in the name of the Participant, in which case the Plan shall be responsible for all actual attorney's fees and expenses incurred in making or attempting to make recovery. If a Participant fails to comply with the subrogation provisions of this contract, particularly, but without limitation, by releasing the Participant's right to secure reimbursement for or coverage of any amounts under any workmen's or worker's compensation act, disability benefit act, or other employee benefit act, as part of settlement or otherwise, the Participant shall reimburse the Plan for all amounts theretofore or thereafter paid by the Plan which would have otherwise been recoverable under such acts and the Plan shall not be required to provide any future benefits for which recovery could have been made under such acts but for the Participant's failure to meet the obligations of the subrogation provisions of this contract. The Participant shall advise the Plan immediately, in writing, if and when the Participant files or otherwise asserts a claim for benefits under any workmen's or worker's compensation act, disability benefit act, or other employee benefit act.

L. Proof Of Claim

As a Participant, it is your responsibility to notify your provider of your participation in the Plan.

Failure to notify a Plan Provider of your membership in the Plan may result in claims not being filed on a timely basis. This could result in a delay in the claim being paid.

If you receive services from a Non-Plan Provider outside the Plan Service Area, obtain and submit an itemized bill and submit to the Plan, clearly indicating the Plan's name and address. If the services were received outside the United States, indicate the appropriate exchange rate at the time the services were received and provide an English language itemized billing to facilitate processing of your claim.

Claims for services from a Non-Plan Provider must be submitted as soon as reasonably possible after the services are received. If the Plan does not receive the claim within 12 (twelve) months, or as soon as reasonably possible, after the date the service was received, the Plan may deny coverage of the claim.

M. Grievance Process

All participating plans are required to make a reasonable effort to resolve members' problems and complaints. If you have a complaint regarding the Plan's administration of these benefits (e.g., denial of claim or referral), you should contact the Plan and try to resolve the problem informally. If the problem cannot be resolved in this manner, you may file a written grievance with the Plan. Contact the Plan for specific information on its grievance procedures.

If you exhaust the Plan's grievance process and remain dissatisfied with the outcome, you may, under certain circumstances, appeal to the Department of Employee Trust Funds by completing an ETF complaint form. You should also submit copies of all pertinent documentation including the written determinations issued by the Plan. The Plan will advise you of your right to appeal to the Department.

You may also request an independent review per § INS 18.11 Wis. Adm. Code. In this event, you must notify the Plan of your request at the same time you notify the Office of the Commissioner of Insurance. In accordance with § INS 18.11 Wis. Adm. Code any determination by an Independent Review Organization is final and binding. You have no further right to administrative review by the Department or Board once the Independent Review Organization decision is rendered.

N. Appeals To The Group Insurance Board

After all other avenues of appeal have been exhausted, the Participant may appeal to the Group Insurance Board for its determination. The Group Insurance Board does not have the authority to hear appeals relating to issues which the contract reserves to the insurer for determination (e.g., determination of medical necessity or whether a treatment or service is experimental). These can be appeals to ETF only to determine whether the Plan breached its contract with the Group Insurance Board.